State of California Department of Consumer Affairs

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS

2535 CAPITOL OAKS DRIVE, SUITE 205
SACRAMENTO, CALIFORNIA 95833
TELEPHONE (916) 263-7800; FAX (916) 263-7859
INTERNET ADDRESS: http://www.bvnpt.ca.gov

ANNUAL REPORT

July 1, 2006 - June 30, 2007

School Name: _____

Check All Appropriate Boxes: ☐ **Vocational Nurse Program** ☐ **Full Time** ☐ **Part Time** ☐ **Psychiatric Technician Program** ☐ **Full Time** ☐ **Part Time**

Program Address: _____

(Street or Box Number) **(City)** **(County)** **(State)** **(Zip)**

Other Program Site: ☐ Yes ☐ No: ***If more than one program site, please duplicate this form and complete information for second site.)***

Initial Approval Date:	**Accreditation Expiration Date:**	**Last Accreditation Survey Date:**

Program Director's Name: _____

Address: _____

Office Telephone: (___)_____ **Fax: (_____)_____** **Email Address:** _____

Administrator's Name: _____

Address: _____

1. **Board approved number of students per class: Full-time:____Part-time:____ Date of Board Approval: Full-time:____Part-time:____**
2. **Board approved frequency of admissions: Full-time:____Part-time:____ Date of Board Approval: Full-time:____Part-time:____**
3. **Please give the following information for the period July 1 last year through June 30 of this year:**

Number of Applications Received		Number of Students Admitted		Number of Students Graduated	
Full-time:	Part-time:	Full-time:	Part-time:	Full-time:	Part-time:

4. **Does the program conduct class during the summer?** ☐ **Yes** ☐ **No**
5. **Does the program articulate with other nursing or PT educational programs?** ☐ **Yes** ☐ **No**
   - ♦ **LVN ⇑ BSN?** ☐ **Yes** ☐ **No**
   - ♦ **LVN ⇑ ADN?** ☐ **Yes** ☐ **No**
   - ♦ **CNA ⇑ LVN?** ☐ **Yes** ☐ **No**
   - ♦ **HHA ⇑ LVN?** ☐ **Yes** ☐ **No**
   - ♦ **LVN ⇑ PT?** ☐ **Yes** ☐ **No**
   - ♦ **LVN ⇑ Other?** ☐ **Yes** ☐ **No**

   Name of program(s) with which you are contracted for articulation:

   _____

   If you do not currently have an articulation agreement, does your program have any plans to articulate with any other program in the future? ☐ **Yes** ☐ **No**
6. **Does the program offer an NCLEX/PN or CAPTLE review course for applicants awaiting the licensure examination?** ☐ **Yes** ☐ **No**
   - ♦ **Is enrollment restricted to students from your program, including repeaters?** ☐ **Yes** ☐ **No**
   - ♦ **Is enrollment open to graduates of all programs?** ☐ **Yes** ☐ **No**
   - ♦ **Is course effectiveness evaluated? (Please attach a summary.)** ☐ **Yes** ☐ **No**
7. **Does the program offer a refresher course for individuals who:**
   - ♦ **Failed prior licensure examinations?** ☐ **Yes** ☐ **No**
   - ♦ **Hold current licensure but have been out of practice for an extended period?** ☐ **Yes** ☐ **No**

   If the program offers a refresher course, is course effectiveness evaluated? ☐ **Yes** ☐ **No**

   If yes, please attach a summary.
8. **Does the program maintain current National League for Nursing Accreditation?** ☐ **Yes** ☐ **No**

CURRICULUM INFORMATION

9. ***Please complete the curriculum information below for <u>every content area</u>. Integrated content should be reflected by enclosing the hours in parentheses.***

Attach a copy of Board correspondence substantiating formal approval of current curricular hours.

Vocational Nursing Programs Only:	Theory		Clinical	
	Hours	Units	Hours	Units
A. Anatomy & Physiology				
B. Nutrition				
C. Psychology				
D. Normal Growth & Development				
E. Nursing Fundamentals				
F. Nursing Process				
G. Communication				
H. Patient Education				
I. Pharmacology				
J. Medical-Surgical Nursing				
K. Communicable Diseases				
L. Gerontological Nursing				
M. Rehabilitation Nursing				
N. Maternity Nursing				
O. Pediatric Nursing				
P. Leadership				
Q. Supervision				
TOTAL HOURS/UNITS:				
TOTAL PROGRAM HOURS/UNITS:				

Psychiatric Technician Programs Only:	Theory		Clinical	
	Hours	Units	Hours	Units
A. Anatomy & Physiology				
B. Nutrition				
C. Psychology				
D. Normal Growth & Development				
E. Nursing Process				
F. Communication				
G. Nursing Science:				
1. Nursing Fundamentals				
2. Med/Surg Nursing				
3. Communicable Diseases				
4. Gerontological Nursing				
H. Patient Education				
I. Pharmacology				
J. Classifications of Developmental Disabilities				
K. Classifications of Mental Disorders				
L. Leadership				
M. Supervision				
TOTAL HOURS/UNITS:				
TOTAL PROGRAM HOURS/UNITS:				

10. **Date of Board Approval for Last <u>Major or Minor</u> Curriculum Revision: _____**

☐ **What were areas of revision? _____**

11. **Indicate type (e.g. full-time, part-time, week-end etc.) and length for each program offered.**

Program Type: _____Length of Program in Weeks:_____ List below the number of weeks per each semester, term, level etc.:

☐ **1st: _____ 2nd: _____ 3rd: _____ 4th: _____ 5th: _____**

Program Type: _____Length of Program in Weeks:_____ List below the number of weeks per each semester, term, level etc.:

☐ **1st: _____ 2nd: _____ 3rd: _____ 4th: _____ 5th: _____**

Program Type: _____Length of Program in Weeks:_____ List below the number of weeks per each semester, term, level etc.:

☐ **1st: _____ 2nd: _____ 3rd: _____ 4th: _____ 5th: _____**

12. **Upon which of the following nursing theories is the program's <u>Conceptual Framework</u> based?**

- ***Check One*: Maslow ☐ Orem ☐ Roy ☐ Other *(Please Specify):* ☐ _____**

Time periods of classes offered by the program:

- **Weekend Classes (Friday through Sunday Theory/Clinical Classes)** ☐ Yes ☐ No
- **Evening Classes (Hours extending beyond 7:00 P.M.)** ☐ Yes ☐ No

14. Does the program offer a Clinical Preceptorship? ☐ Yes ☐ No

Length: ☐ **0 – 40 Hrs.** ☐ **41 – 80 Hrs.** ☐ **81 – 120 Hrs.** ☐ **121 – 160 Hrs.**

Please check all <u>admission criteria</u> which are applicable to your program.

A. High School Graduation ☐ Yes ☐ No
   - VN Programs: 17 Years of Age ☐ Yes ☐ No
   - PT Programs: 18 Years of Age ☐ Yes ☐ No

   Do you secure proof of 12th grade equivalency before admission? ☐ Yes ☐ No

B. Specific Screening Instrument
   - California Proficiency Achievement Test ☐ Yes ☐ No
   - Test of Adult Basic Education ☐ Yes ☐ No
   - Wonderlic ☐ Yes ☐ No
   - Other: (Please Specify)* _____ ☐ Yes ☐ No

C. Other: (Please Specify)* _____ ☐ Yes ☐ No

16. Please check all <u>selection criteria</u> which are applicable to your program.

A. Random Selection ☐ Yes ☐ No
B. Grade Point Average ☐ Yes ☐ No
C. Examination Scores: (Specify Minimum)*_____ ☐ Yes ☐ No
D. Reading Scores: (Specify Minimum)*_____ ☐ Yes ☐ No
E. Other: (Please Specify)* ☐ Yes ☐ No

17. Please check all <u>prerequisites</u> which are applicable to your program.

A. Nurse Assistant Certification ☐ Yes ☐ No
B. Home Health Aide Certification ☐ Yes ☐ No
C. CPR Certification ☐ Yes ☐ No
D. Academic Courses: (Please Specify)*_____ ☐ Yes ☐ No
E. Other: (Please Specify)* ☐ Yes ☐ No

18. Please indicate the following information relative to your program's <u>faculty meetings</u>.

A. Meeting Frequency:
   ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____

B. Meeting Content (Please specify frequency)
   - Curriculum Evaluation and Revision:
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____
   - Evaluation of Student Achievement:
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____
   - Program Evaluation:
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____
   - Effectiveness of Remediation:
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____
   - Criteria for Academic Probation:
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____
   - Facility Evaluation
     ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other_____

*If additional space is needed, please provide information on a separate page.

DATA ON CULTURAL DIVERSITY

During the current nursing shortage crisis, the Board is asked by the legislature and the governor's office for data related to cultural diversity of the nurse workforce in California. For that reason, the following data is requested. The data will be reported in the aggregate and no individual program will be identified.

Please complete the table below by listing the number of students in each category for **all** classes **starting** or **graduating** in your program during this reporting period (**July 1, 2006- June 30, 2007**). For example:

Example

Class Start Date	Projected Graduation Date	African-American	Asian/Pacific Islander	Caucasian	Hispanic	Native American	Other
09/06/03	**12/15/04 (this class graduated in this reporting period)**	10	10	10	10	10	10
09/05/04 (this class started in this reporting period	12/15/05	12	5	15	8	1	3

Class Start Date	Projected Graduation Date	African-American	Asian/Pacific Islander	Caucasian	Hispanic	Native American	Other

I hereby certify under penalty of perjury under the laws of the State of California that the information contained in this Annual Report is true and correct.

Program Director's Signature: _____ Date: _____

THANK YOU FOR YOUR COOPERATION

Attachment A: Faculty Information

Attachment A reflects all Board-approved faculty for your program. Please mark through any names of faculty who no longer teach for your program. Add any names of Board-approved faculty that do teach for your program but do not appear on the list. The legend for Attachment A follows:

** **Degree:** **A** = Associate Degree; **B** = Bachelors Degree; **M** = Masters Degree; **D** = Doctoral Degree

*** **Position Codes**: **D** = Director; **AD** = Asst. Director; **I** = Instructor or Substitute (nursing); **AF** = Additional Faculty; **TA** = Teacher Assistant

**** **Work Schedule**: **FT** = Full-Time **PT** = Part-Time **S** = Substitute

Attachment B: Clinical Facility Information

Attachment B reflects all Board - approved clinical facilities in which you have indicated that your program's students received clinical experience during the last 24 months. Facilities not utilized within that time frame will be deleted from your program's list of approved clinical facilities. Future use will necessitate the completion of a new Clinical Facility Approval form. Please mark through any names of facilities you no longer use. Add any names of Board-approved facilities that you use, but do not appear on the list. The legend for Attachment B follows:

* **Non Use:** Please place a check in this column if the designated facility was not utilized for clinical experience during the last 24 months.

** **Facility Codes:** **AC** = Acute Care; **AS** = Ambulatory Surgery; **COM** = Community Care; **COR** = Corrections; **DC** = Day Care; **GH** = Group Homes; **HH** = Home Health; **IC** = Intermediate Care; **LTC** = Long Term Care; **OP** = Outpatient; **PO** = Physician's Office; **P** = Preschool; **R** = Rehabilitation; **SNF** = Skilled Nursing Facility; **STP** = Specialty Treatment Programs; **SS** = Special Schools; **TC** = Transitional Care; **O** = Other **(Please Specify)**

PT Programs Only - **CDU** = Chemical Dependency Unit; **MHC** = Mental Health Clinics; **PH** = Psychiatric Hospitals; **VE** = Vocational Education & Training Centers;

*** **Clinical Use Codes:** **Fun** = Fundamentals/Nursing Science; **M/S** = Medical/Surgical; **C.Dis**.= Communicable Diseases; **Geron** = Gerontological Nursing; **Rehab** = Rehabilitation Nursing; **Matern** = Maternity Nursing; **Ped** = Pediatric Nursing; **L/S** = Leadership & Supervision.

PT Programs Only - **MD** = Mental Disorders; **DD** = Developmental Disabilities.